Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KELL WEST REGIONAL HOSPITAL
5420 KELL W BOVD
WICHITA FALLS TX 76310

Respondent Name
Texas Mutual Insurance Company

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-3524-01

MFDR Date Received
August 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Emergency Room"

Amount in Dispute: $1,056.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2012	Outpatient Hospital Services	$1,056.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 13, 2012
   - CAC-B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 242 – NOT TEATING DOCTOR APPROVED TREATMENT
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2." Per rule 134.600(p)(12), Non-emergency health care requiring preauthorization includes treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols." 28 Texas Administrative Code §133.2(4)(A) states that, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
    a. EMERGENCY NURSING RECORD shows patient to be in mild distress.
    b. Patient states pain level to be 6 out of 10.
    c. Patient refused analgesic.
2. The Division concludes the denial code 899 is supported.
3. The requestor is seeking $1,056.50. This amount cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 12, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.